STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505498	A. Building B. Wing	12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchmark on South Hill Nursing	2929 South Waterford Drive Spokane, WA 99203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527 Based on observation, interview and record review, the facility failed to provide the level of supervision necessary to prevent choking for four of six sampled residents (1, 2, 3, 4), reviewed for supervision with eating. Additionally, the facility failed to provide all interventions necessary to assist a resident who choked while eating unsupervised (1). This failure resulted in an Immediate Jeopardy (IJ) on [DATE], for Resident 1, who died on [DATE] after eating while unsupervised, and was not provided the emergency medical assistance measures required. Furthermore, this failure placed additional residents who required assistance with eating at risk for aspiration, choking, and death. Findings included . On [DATE] at 4:20 PM, the facility was notified of an IJ at CFR 483.25 (d)(1)(2) F689, Free of Accident/Hazards/Supervision/Devices, related to the facility's failure to implement key interventions to prevent and respond to resident choking. The facility removed the immediacy on [DATE] with an onsite verification from investigators by ensuring all residents who needed assistance with eating were identified, implementing measures to communicate that need to staff, and re-education of all staff regarding facility methods of communication of resident needs, and when emergency medical services should be called. Per the facility's undated policy titled, Touchmark Skilled Nursing Emergency CPR (Cardiopulmonary resuscitation; a lifesaving technique used when the heart has stopped beating and/or breathing has stopped) procedure, if an individual was found unresponsive, staff were to verify the code status of the individual, and instruct a staff member to call 911. The code status was to be found in the resident's closet care plan (a copy of the care plan posted in the resident's closet) on the top right corner and in the front of the resident's medical record. Resident 1 Review of Resident 1's POLST (physician orders for life-sustaining treatment) form, signed [DATE] by Resident 1 and [DATE] by Staff B, Nurse Practitioner, showed Resident 1 was to have selective treatment if they had a pulse and/or were breathing. Selective treatment included medical treatment and transfer to a hospital if indicated. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 1's closet care plan, dated [DATE], showed they were to be upright and alert for all oral intake, were to eat their meals in the restorative dining room (a dining program to assist residents with achieving or maintaining feeding skills), were to alternate small bites and small sips, required cues to attend to food due to inattention, and all solid intake was to be supervised. Additionally, the top right corner was marked NO CODE, which referred to the treatment the resident was to receive if they had no pulse and were not breathing. The selective treatment wishes related to if the resident was still breathing and/or had a pulse was not included (see previous paragraph). On [DATE] at 10:30 AM, Staff H, Speech and Language Pathologist (SLP; a health care professional trained to evaluate and treat people who have voice, speech, language, swallowing or hearing disorders, especially those that affect their ability to communicate or consume food), stated Resident 1 had a long history of difficulty swallowing and had a choking incident in the facility in [DATE] that required hospitalization . Per Staff H, the resident previously refused to participate in restorative dining as recommended but agreed to participate after returning to the facility following the most recent hospital stay. Staff H stated the resident required staff to stay with them at the bedside (1:1) while they ate to provide appropriate cueing and reminders for safe swallowing, and the resident should not have any solid foods, including snacks, unless staff were present in the room. In an interview on [DATE] at 10:10 AM Staff D, Registered Nurse (RN), stated around 10:40 PM on [DATE] they entered Resident 1's room to give the resident's roommate their bedtime medications, and found Resident 1 slumped over in bed, vomiting. Staff D stated they yelled for help, and Staff C, RN, came and took over care of the resident while they monitored the resident's pulse. Per Staff D, Staff C attempted the Heimlich maneuver (a first aid method for choking) and was unsuccessful, so Staff C attempted to suction out the resident's mouth. Per Staff D the two nurses were with the resident attempting to provide care for approximately 15 to 20 minutes before the resident's pulse was no longer detected and Resident 1 showed other signs of death. Per Staff D, Staff C was more familiar with both the resident and the facility, and notified them that the resident was a NO CODE when they first entered the room, so emergency services were not called. In an interview on [DATE] at 10:30 PM Staff C, RN, stated Resident 1 ate a snack unattended by staff during the night of [DATE], and was found slumped over in bed by Staff D, RN, shortly before 11:00 PM, throwing up and turning blue. Per Staff C, the two nurses checked the resident's mouth for a blockage, and suctioned out the resident's mouth, but did not perform CPR or call for emergency assistance because the resident was a NO CODE. Staff C also stated the resident had previously choked in a dining room during the daytime a few weeks ago, and emergency personnel were able to transfer the resident to the hospital and provide life-saving treatment during that incident, but did not provide any additional data as to why emergency services were not obtained for the most recent choking incident. When asked about supervision the resident was provided while eating, Staff C stated the resident was sitting upright and had fluid in reach, and staff would check in on them between other tasks (outside the resident's room) and had not had any issues with eating independently on previous nights. Staff C did not acknowledge the care plan interventions for close supervision and cueing while eating, though they verbalized knowing the resident was receiving speech therapy to assist with their swallowing ability. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 12:45 PM Staff E, Nursing Assistant (NA), stated on [DATE] after 10:00 PM they provided Resident 1 with a snack in bed, which the resident ate independently without problems, then provided a second snack at the resident's request, with the permission of Staff C. Staff E stated they did not remain in the room with the resident to provide assistance while they ate, and they first became aware of a problem when Staff D went into the resident's room and yelled for help. Per Staff E, residents had care plans with instructions on assistance required for activities of daily living in their room, in a binder at the nurse's station, and on the computer; however, they were not aware of Resident 1 ever having a swallowing problem or specialized diet/feeding instructions. Additionally, Staff E stated they remained in the room while Staff C and D, Registered Nurses, provided care to the resident, and was not instructed to call for assistance at any point during the incident. In an interview on [DATE] at 11:33 AM, Staff B, Nurse Practitioner, stated they were not called for direction during the incident, and was notified of Resident 1's death afterwards, on the night of [DATE]. Staff B confirmed emergency services should have been called and Resident 1 should have been transferred to the hospital per the wishes listed on their POLST form. In an interview on [DATE] at 10:44 AM, a representative for Resident 1 stated the resident had a choking incident in October of 2022 and required emergency services as well as hospitalization . Per the representative, the resident would have wanted similar treatment for the choking incident on [DATE], as listed on their POLST form. Resident 3 In an interview on [DATE] at 11:05 AM, Staff I, RN, who worked on a temporary basis, stated they had concerns about residents other than Resident 1 (see above) choking, as well as concerns of lack of reporting resident incidents to facility management by facility staff. Review of the [DATE] nursing progress notes for Resident 3 showed an entry dated [DATE] by Staff C, Registered Nurse, that the resident was being monitored after a choking incident the evening prior. There were no notes from [DATE] with details about the incident, although there were additional notes through [DATE] showing continued monitoring of the resident following a choking incident. In an interview on [DATE] at 10:30 PM, Staff C denied awareness of any residents in the facility, other than Resident 1, with recent choking incidents. Review of the [DATE] facility incident Reporting Log showed no reported choking incidents. In an interview on [DATE] at 4:30 PM, Staff A, Administrator, was asked about an investigation for the choking incident documented in Resident 3's nursing notes. Staff A stated they were unaware of the incident and confirmed it was not listed on the incident Reporting Log. Per the [DATE] quarterly assessment, Resident 3 had a diagnosis of difficulty swallowing following a stroke. Review of Resident 3's closet care plan, dated [DATE], showed they ate in the dining room; restorative dining was not marked. Per the care plan, the resident required set up and cueing assistance with eating. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] resident census sheet included brief information about residents, including which dining room they were to eat in. Resident 3 was identified as requiring restorative dining on the census sheet. On [DATE] at 5:35 PM Resident 3 was observed slowly eating in the main dining room. Multiple unidentified staff members and Staff F, Nursing Assistant, periodically entered and left the dining room, intermittently leaving Resident 3 (who was distracted by the staff entering and leaving the room) and other unsampled residents, eating without supervision. No staff members were observed cueing, or otherwise interacting with Resident 3 during the meal. Resident 2 Review of Resident 2's closet care plan, dated [DATE] showed they ate in the dining room; restorative dining was not marked. The level of assistance with feeding was marked as both independent and required cueing. Review of the [DATE] resident census sheet showed Resident 2 was to eat in the restorative dining room. In an observation on [DATE] at 5:20 PM, Resident 2 was lying in bed while meal service was provided throughout the facility. At 5:50 PM the same day, an uneaten meal tray labeled with Resident 2's name was observed outside the door of their room, while the resident continued to sleep in bed. In an interview at the same time, Staff G, Nursing Assistant, stated the resident required supervision and usually ate in the restorative dining room, but was tired and had refused dinner that night. When asked about supervision with eating either their meal or a snack if the resident became hungry later in the evening, Staff G stated they did not know how that would work out and asked Staff F, Nursing Assistant. Staff F was unable to provide information on the level of supervision staff would provide to Resident 2 if they ate outside of the dining room. In an interview on [DATE] at 10:30 AM, Staff H, SLP, stated residents who needed supervision with eating ate in the restorative dining room during meals, and required staff supervision if they ate in their room. Resident 4 Per the admission assessment dated [DATE], Resident 4 had a diagnosis of difficulty swallowing. Review of Resident 4's closet care plan, dated [DATE], showed the resident was to eat in the restorative dining room. The level of assistance with feeding was marked as both independent and required cueing. On [DATE] at 10:30 AM, Staff H, SLP, stated residents who ate in the restorative dining room had a staff member sit with them at the table, providing the identified assistance necessary. In a follow up interview at 12:45 on [DATE], Staff H stated staff were notified of which residents ate in the restorative dining room via the daily resident census sheet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation at 5:35 PM on [DATE] Resident 4 was slowly eating in the restorative dining room with no staff in attendance at their table. Staff G, Nursing Assistant, was seated at a table across the room monitoring and providing assistance to other unsampled residents. Staff G was not cueing Resident 4, and no additional staff were present in the restorative dining room to provide the cueing identified in the resident's care plan. Resident 4 did not complete their meal prior to staff removing them from the dining room. In an interview at the time of the observation, Staff G stated they were not permanently employed by the facility (temporary agency staff), so they were not familiar with individual resident care needs. Staff G stated they knew which residents should be in restorative dining based on the daily resident census sheet, which noted where residents were to eat, but relied on facility staff to bring the appropriate residents into the restorative dining room and notify them of resident care needs. Reference (WAC) [DATE](3)(g)